COLORADO DEPARTMENT OF REGULATORY AGENCIES

Division of Insurance

3 CCR 702-4

Amended Regulation 4-2-20

Concerning the Colorado Health Benefit Plan Description Form

Section 1. Authority

This regulation is promulgated pursuant to Sections 10-1-109, 10-3-1110(1), 10-16-108.5(11)(b), and 10-16-109, C.R.S.

Section 2. Scope and Purpose

The purpose of this regulation is to establish and implement rules concerning the format for, elements of, and issuance of a Colorado Health Benefit Plan Description Form, pursuant to Section 10-16-108.5(11)(b), C.R.S. As required by law, the form is designed to facilitate comparison of different health plans by persons interested in purchasing or obtaining coverage under a health benefit plan. As also required by law, this regulation sets out procedures for carriers to make available a Colorado Health Benefit Plan Description Form for each policy, contract, and plan of health benefits that either covers a Colorado resident or is marketed to a Colorado resident or such resident's employer. This regulation is being changed in response to concerns from interested parties.

Section 3. Applicability

This amended regulation shall apply to all carriers offering or providing health benefit plan coverage or Medicare supplemental coverage on and after July 1, 2007.

Section 4. Rules

A. Effective July 1, 2007, all carriers offering or providing health benefit plan coverage or Medicare supplemental coverage shall make available to a producer or consumer through electronic means or hard copy, a completed copy of the Colorado Health Benefit Plan Description Form shown in Appendix A for each policy, contract, and plan of health benefits that either covers a Colorado resident or is selected by a Colorado resident or such resident's employer as one of the final choices from which the ultimate selection will be made, except as provided in Part B of Section 4 of this regulation.

B Carriers marketing or providing a Medicare supplemental plan will be deemed to have met the requirement of Part A of Section 4 of this regulation if, in lieu of the Colorado Health Benefit Plan Description Form, they make available for each such plan a Medicare supplement outline of coverage as prescribed in Colorado insurance regulation 4-3-1, 3 C.C.R. 702-4. Carriers shall make available the Medicare supplement Outline of Coverage pursuant to Part E of Section 4 below.

C. Carriers shall use the exact format found in Appendix A for the Colorado Health Benefit Plan Description Form, including all headings, notes, row numbers, and footnotes. All boxes must be filled in. Carriers may modify box dimensions, reduce margins, or use a landscape rather than a portrait page layout format, but carriers shall follow the exact requirements and use only the choices set forth in the directions found in Appendix B of this regulation. A carrier may also add its logo to the form and print the form in color or black and white. Pursuant to Section 10-3-

1104(1), C.R.S., in completing the form, carriers shall not misrepresent the benefits, advantages, conditions, or terms of the policy.

D. Carriers shall follow the directions for completing the Colorado Health Benefit Plan Description Form found in Appendix B of this regulation.

E. Carriers shall provide a Colorado Health Benefit Plan Description Form that is specific with respect to the particular policy provisions of the policy (e.g., individual deductible = $500 per year) as follows:

1. Automatically, as part of the health benefit plan description materials given to employees or members of a group, association or health care cooperative who have the option of selecting such an employer-sponsored, group-sponsored, association-sponsored, or cooperative-sponsored plan when they initially become eligible for coverage and thereafter during any open enrollment period;

2. Automatically within three (3) business days of a potential policyholder expressing interest in a particular plan or such plan being selected as a finalist from which the ultimate selection will be made (e.g., “I am interested in the Gold Plan, the $500 deductible PPO plan, your HMO plan with vision care coverage, etc,” or “I want to purchase your Plan 200, $5 copay HMO plan,” etc.);

3. Upon request, within three (3) business days, to any person who is interested in coverage under or who is covered by a health benefit plan of the carrier; and

4. Upon request within three (3) business days to a producer on behalf of any person, group, association, or health care cooperative that is interested in coverage or is covered by a health benefit plan of the carrier.

F.

1. Carriers shall prominently include with all marketing materials the following notice:

"Colorado law requires carriers to make available a Colorado Health Benefit Plan Description Form, which is intended to facilitate comparison of health plans. The form must be provided automatically within three (3) business days to a potential policyholder who has expressed interest in a particular plan or who has selected the plan as a finalist from which the ultimate selection will be made. The carrier also must provide the form, upon oral or written request, within three (3) business days, to any person who is interested in coverage under or who is covered by a health benefit plan of the carrier."

2. The carrier shall ensure that the form is given to the person making the request within three (3) business days of receipt of such request. The request may be made orally or in writing and may be made to either a carrier or a producer.

G. Concerning the carrier’s obligation contained in Part E(1) of Section 4 to make the health benefit plan description form available to employees, or members of a group, association, or health care cooperative, a carrier is in compliance if:

1. The carrier provides the health benefit description form to the group, association, or health care cooperative, or to a producer on behalf of the group, association, or health care cooperative, or to an individual; or

2. The carrier determines that the employer has developed and will distribute or has distributed a conforming grid.

a. A grid is conforming if an employer offers an employee a choice of health plans and compares the benefits for the plans on a grid that meets all the following requirements:

(1) The grid must follow the exact format contained in Appendix A for the Colorado Health Benefit Plan Description Form, including the labeling and numerical identification of rows and columns, the headings, the footnotes, and the notes, except as set forth in subparagraph (b), below.

(2) At the employer's sole discretion, the grid also may include additional rows, as long as the numbering of those rows does not interfere with the ordering and numbering of rows established in Appendix A. For example, the "PRESCRIPTION DRUGS" row is always row 11 on the grid; the "HOSPICE CARE" row is always row 26 on the grid. In addition, the employer grid could include more rows (e.g., "10A INFERTILITY TREATMENT," "11A. CONTRACEPTIVES," "31A NATUROPATHY").

(3) The benefit descriptions in the grid must follow exactly the directions contained in Appendix B of this regulation for completing the grid, except as set forth in subparagraph (b), below.

(4) At the employer's sole discretion, the benefit descriptions may include additional relevant information.

(5) The grid must be given to all new enrollees, to all employees eligible for coverage during any open enrollment periods, and, upon request, to any covered employee and any person interested in obtaining coverage.

(6) The grid may contain several columns comparing the benefits of the different plans available to the employer's employees, which shall also conform to this regulation.

b. Where employees of an employer or members of a health care purchasing cooperative are given a choice of two or more plans, the form may be further modified as follows. Where a specific benefit for all plans is the same, the comparison grid may simply describe that same benefit once, across all columns, for all plans, or state "see rider" across all columns, for all plans. For example:

EXAMPLE

	HMO A	HMO B	PPO Z
		In-Network	Out-of- Network
28. DENTAL CARE	See rider.		
29. VISION CARE	All plans cover up to $50 per year toward eyeglasses.		

c. Nothing in this regulation shall be construed to require an employer to develop or use a grid for comparing employee benefit plan choices.

H. With respect to the specific Colorado Health Benefit Plan Description Form required to be made available by carriers pursuant to Part E(1) of Section 4, a carrier shall develop a separate Colorado Health Benefit Plan Description Form for each of its policies, contracts, and plans of benefits. If a carrier offers a policy with a choice of copayments, coinsurance levels, deductibles,

lifetime maximums, annual maximums, and/or other benefit maximums, minimums or restrictions, the carrier shall provide a separate Colorado Health Benefit Plan Description Form specific to the particular benefits of the policy being sold, marketed, or that is in place.

I. The Colorado Health Benefit Plan Description Form is designed to be a stand-alone piece describing a health benefit plan. The forms should not include attachments, except that a carrier may:

1. Attach a list of exclusions developed pursuant to Part K of Section 4 of this regulation;

2. Attach information on premiums;

3. Attach information on riders;

4. Include as an attachment information specifying the plan's cancer screening coverages and their respective parameters, as required by Section 10-16-108.5(11)(c), C.R.S.;

5. Include at the end of the form or as an attachment information that is statutorily required of marketing materials (e.g., for managed care plans, disclosure of the existence and availability of an access plan, as required pursuant to Section 10-16-704(1), (2) and (9), C.R.S.); or

6. Include the Optional Attachment, "Selected Benefit Descriptions," that appears at the end of the Colorado Health Benefit Plan Description Form.

J. A carrier shall make a list of policy exclusions available immediately upon request (but in no event more than three (3) business days after the request) for each of its health benefit plans.

K. The Colorado Health Benefit Plan Description Forms developed for each policy, contract, and plan of benefits shall be in standard, easy-to-read type sizes and fonts, of no less than 10 points.

Section 5. Enforcement

Noncompliance with this regulation is a violation of Section 10-3-1104, C.R.S., and subject to the sanctions specified in Section 10-3-1108, C.R.S., including the imposition of fines and the suspension or revocation of insurance licenses and/or certificates of authority.

Section 6. Severability

If any provision of this regulation is for any reason held to be invalid, the remainder of the regulation shall not be affected.

Section 7. Effective Date

This amended regulation is effective on July 1, 2007.

Section 8. History

- Hearing date: September 10, 1997; Effective: November 15, 1997
- Hearing date: August 4, 1998: Effective date: September 30, 1998.
  - Amended Sections 1,2,3,4,7, Appendix A, and Appendix B.
- Hearing date: March 2003, Effective: January 1, 2004.
- Hearing date: August 4, 2004; Effective: January 1, 2005
- Amended effective July 1, 2007.

NOTE: An unofficial copy of this amended regulation, including the description form, is available on the Colorado Division of Insurance web site on the Internet at: http://www.dora.state.co.us/insurance/regs

Appendix A

Colorado Health Benefit Plan Description Form

_____
Name of Carrier

_____
Name of Plan

Part A: TYPE OF COVERAGE

1. TYPE OF PLAN	
2. OUT-OF-NETWORK CARE COVERED?[1]	
3. AREAS OF COLORADO WHERE PLAN IS AVAILABLE	

PART B: SUMMARY OF BENEFITS

Important Note: This form is not a contract, it is only a summary. The contents of this form are subject to the provisions of the policy, which contains all terms, covenants and conditions of coverage. Your plan may exclude coverage for certain treatments, diagnoses, or services not noted below. The benefits shown in this summary may only be available if required plan procedures are followed (e.g., plans may require prior authorization, a referral from your primary care physician, or use of specified providers or facilities). Consult the actual policy to determine the exact terms and conditions of coverage. Coinsurance and copayment options reflect the amount the covered person will pay.

	IN-NETWORK	OUT-OF-NETWORK
4. Deductible Type[2]		
4a. ANNUAL DEDUCTIBLE[2a] **a) [Individual] [Single][2b]** **b) [Family] [Non-single][2c]**		
5. OUT-OF-POCKET ANNUAL MAXIMUM[3] **a) Individual** **b) Family** **c) Is deductible included in the out-of-pocket maximum?**		
6. LIFETIME OR BENEFIT MAXIMUM PAID BY THE PLAN FOR ALL CARE		
7A. COVERED PROVIDERS		
7B. With respect to network plans, are all the providers listed in 7A accessible to me through my primary care physician?		**Not applicable.**
8. MEDICAL OFFICE VISITS[4] **a) Primary Care Providers** **b) Specialists**		

9. PREVENTIVE CARE **a) Children's services** **b) Adults' services**		
10. MATERNITY **a) Prenatal care** **b) Delivery & inpatient well baby care[5]**		
11. PRESCRIPTION DRUGS[6] Level of coverage and restrictions on prescriptions.		
12. INPATIENT HOSPITAL		
13. OUTPATIENT/AMBULATORY SURGERY		
14. DIAGNOSTICS **a) Laboratory & x-ray** **b) MRI, nuclear medicine, and other high-tech services**		
15. EMERGENCY CARE[7, 8]		
16. AMBULANCE		
17. URGENT, NON-ROUTINE, AFTER HOURS CARE		
18. BIOLOGICALLY-BASED MENTAL ILLNESS CARE[9]		
19. OTHER MENTAL HEALTH CARE **a) Inpatient care** **b) Outpatient care**		
20. ALCOHOL & SUBSTANCE ABUSE		
21. PHYSICAL, OCCUPATIONAL, & SPEECH THERAPY		
22. DURABLE MEDICAL EQUIPMENT		
23. OXYGEN		
24. ORGAN TRANSPLANTS		
25. HOME HEALTH CARE		
26. HOSPICE CARE		
27. SKILLED NURSING FACILITY CARE		
28. DENTAL CARE		
29. VISION CARE		
30. CHIROPRACTIC CARE		
31. SIGNIFICANT ADDITIONAL COVERED SERVICES (list up to 5)		

PART C: LIMITATIONS AND EXCLUSIONS

32. PERIOD DURING WHICH PRE-EXISTING CONDITIONS ARE NOT COVERED.[10]	
33. EXCLUSIONARY RIDERS. Can an individual's specific, pre-existing condition be entirely excluded from the policy?	
34. HOW DOES THE POLICY DEFINE A "PRE-EXISTING CONDITION"?	
35. WHAT TREATMENTS AND CONDITIONS ARE EXCLUDED UNDER THIS POLICY?	Exclusions vary by policy. A list of exclusions is available immediately upon request from your carrier, agent, or plan sponsor (e.g., employer). Review the list to see if a service or treatment you may need is excluded from the policy.

PART D: USING THE PLAN

	IN-NETWORK	**OUT-OF-NETWORK**
36. Does the enrollee have to obtain a referral and/or prior authorization for specialty care in most or all cases?		
37. Is prior authorization required for surgical procedures and hospital care (except in an emergency)?		
38. If the provider charges more for a covered service than the plan normally pays, does the enrollee have to pay the difference?		
39. What is the main customer service number?		
40. Whom do I write/call if I have a complaint or want to file a grievance?[11]		
41. Whom do I contact if I am not satisfied with the resolution of my complaint or grievance?		
42. To assist in filing a grievance, indicate the form number of this policy; whether it is individual, small group, or large group; and if it is a short-term policy.		
43. Does the plan have a binding arbitration clause?		

Endnotes

1 “Network” refers to a specified group of physicians, hospitals, medical clinics and other health care providers that your plan may require you to use in order for you to get any coverage at all under the plan, or that the plan may encourage you to use because it may pay more of your bill if you use their network providers (i.e., go in-network) than if you don’t (i.e., go out-of-network).

2 “Deductible Type” indicates whether the deductible period is “Calendar Year” (January 1 through December 31) or “Benefit Year” (i.e., based on a benefit year beginning on the policy's anniversary date) or if the deductible is based on other requirements such as a “Per Accident or Injury” or “Per Confinement”.

2a “Deductible” means the amount you will have to pay for allowable covered expenses under a health plan during a specified time period (e.g., a calendar year or benefit year) before the carrier will cover those expenses. The specific expenses that are subject to deductible may vary by policy. Expenses that are subject to deductible should be noted in boxes 8 through 31.

2b “Individual” means the deductible amount you and each individual covered by a non-HSA qualified policy will have to pay for allowable covered expenses before the carrier will cover those expenses. “Single” means the deductible amount you will have to pay for allowable covered expenses under an HSA-qualified health plan when you are the only individual covered by the plan.

2c “Family” is the maximum deductible amount that is required to be met for all family members covered by a non-HSA qualified policy and it may be an aggregated amount (e.g., “$3,000 per family”) or specified as the number of individual deductibles that must be met (e.g., “3 deductibles per family”). “Non-single” is the deductible amount that must be met by one or more family members covered by an HSA-qualified plan before any covered expenses are paid.

3 "Out-of-pocket maximum" means the maximum amount you will have to pay for allowable covered expenses under a health plan, which may or may not include the deductibles or copayments, depending on the contract for that plan. The specific deductibles or copayments included in the out-of-pocket maximum may vary by policy. Expenses that are applied toward the out-of-pocket maximum should be noted in boxes 8 through 31.

4 Medical office visits include physician, mid-level practitioner, and specialist visits, including outpatient psychotherapy visits for biologically based mental illness.

5 Well baby care includes an in-hospital newborn pediatric visit and newborn hearing screening. The hospital copayment applies to mother and well-baby together; there are not separate copayments.

6 Prescription drugs otherwise excluded are not covered, regardless of whether preferred generic, preferred brand name, or non-preferred.

7 “Emergency care” means all services delivered in an emergency care facility that are necessary to screen and stabilize a covered person. The plan must cover this care if a prudent lay person having average knowledge of health services and medicine and acting reasonably would have believed that an emergency medical condition or life or limb threatening emergency existed.

8 Non-emergency care delivered in an emergency room is covered only if the covered person receiving such care was referred to the emergency room by his/her carrier or primary care physician. If emergency departments are used by the plan for non-emergency after-hours care, then urgent care copayments apply.

9 “Biologically based mental illnesses” means schizophrenia, schizoaffective disorder, bipolar affective disorder, major depressive disorder, specific obsessive-compulsive disorder, and panic disorder.

10 Waiver of pre-existing condition exclusions. State law requires carriers to waive some or all of the pre-existing condition exclusion period based on other coverage you recently may have had. Ask your carrier or plan sponsor (e.g., employer) for details.

11 Grievances. Colorado law requires all plans to use consistent grievance procedures. Write the Colorado Division of Insurance for a copy of those procedures.

Optional Attachment

Selected Benefit Descriptions
Colorado Health Benefit Plan Description Form Addendum

_____
Name of Carrier

_____
Name of Plan

_____
Individual/Group Name and/or Number (optional)

Benefit	Benefit Level
4. Deductible Type	
4a. ANNUAL DEDUCTIBLE **a) [Individual] [Single]** **b) [Family] [Non-single]**	
5. OUT-OF-POCKET ANNUAL MAXIMUM **a) Individual** **b) Family**	
6. LIFETIME OR BENEFIT MAXIMUM PAID BY THE PLAN FOR ALL CARE	
11. PRESCRIPTION DRUGS Level of coverage and restrictions on prescriptions.	
19. OTHER MENTAL HEALTH CARE **a) Inpatient care** **b) Outpatient care**	
20. ALCOHOL & SUBSTANCE ABUSE	
22. DURABLE MEDICAL EQUIPMENT	
28. DENTAL CARE	
29. VISION CARE	
30. CHIROPRACTIC CARE	

Appendix B

Directions for Filling Out the Colorado Health Benefit Plan Description Form

TOP OF FORM

Carrier and plan names. Fill in complete carrier name on the first line and the name of the plan on the second line. Plans may also include the following information, if they wish to do so, either at the top of the form, at the bottom of the page, or at the end of the document: carrier logo, group identification number, class or division, and effective date.

PART A: TYPE OF COVERAGE

Question 1, Type of Plan. Enter type of plan. Select one of the following choices only: (1)"Medical expense policy," (2) "Hospital expense policy," (3) "Preferred provider plan," (4) "Health maintenance organization (HMO)," (5) "Point of service (i.e., an HMO plan with some out-of-network benefits)," or (6) "Limited service licensed provider network (LSLPN) plan." Note: Plans that have in-network and out-of-network benefits that are not offered by an HMO but which use gatekeepers should enter "Preferred Provider Plan."

Question 2, Coverage for Out-of-Network Care. Indicate if out-of-network care is covered. Select one of the following choices only: (1) "Only for emergency care"; (2) " Only for emergency and urgent care"; (3) "Only for specified services; patient pays more for such out-of-network care" [e.g., POS plans]; (4) "Yes, but patient pays more for out-of-network care." [e.g., PPO's]; (5) "Yes; policy makes no distinction between in-network and out-of-network care." [e.g., traditional indemnity plans]. (6) For HMOs that are marketing to small employers or employees of small employers outside of its geographic service area, the following statement must be added in bold, 12 pt. caps:

"INTERESTED POLICYHOLDERS, CERTIFICATE HOLDERS, AND ENROLLES ARE HEREBY GIVEN NOTICE THAT THIS SMALL GROUP POLICY REQUIRES THAT AN INSURED TRAVEL OUTSIDE OF THE GEOGRAPHIC AREA TO RECEIVE COVERED HEALTH BENEFITS."

Question 3, Where Plan Is Available. Indicate where the plan itself is available. This question does not concern the residence of the potential enrollee. Select one of the following choices only: (1) "Plan is available throughout Colorado"; (2) "Plan is available only in the following areas: [fill in]"; or (3) "Plan is available throughout Colorado except in the following areas: [fill in]." A note should be added if the Plan is marketed to employers or employees located over state or county lines.

PART B: SUMMARY OF BENEFITS

Questions 4-31: General Directions.

- If the plan has separate in-network and out-of-network benefits (e.g., preferred provider plan), use two columns and label them "In-network" and "Out-of-network."

- If the plan does not make such a distinction (e.g., traditional indemnity plan) replace two columns with a single column labeled "Benefit Levels."

- HMOs may use one rather than two columns to describe their benefits. HMOs that decide to use one column only should label that column as follows: "In-Network Only (out-of network care is not covered except as noted)." Wherever the plan does provide out-of-network care (e.g., emergency care), this should be noted in the appropriate boxes describing benefits. Point of service plans and preferred

provider plans should continue to use two columns—one for in-network and one for out-of-network coverage—to describe their plans.

- For questions 4-6, 11, 19-20, 22 and 28-30, carriers may write in "See benefit schedule attached" and show actual benefit levels on a separate schedule attached to the form. Carriers that choose to use a separate schedule for the designated questions shall use the form labeled "Selected Benefit Descriptions," which is found at the end of the description form and labeled Optional Attachment. The same rules apply for filling out the boxes on this optional form as on the main description form.

Question 4, Deductible Type*. Enter "Calendar Year" or "Benefit Year". If the deductible is anything other than per calendar or benefit year, the specific requirements must be disclosed here.

Question 4a, Annual Deductible*. Specify "Individual" and "Family" for non-HSA qualified plans or "Single" or "Non-single" for HSA-qualified plans. Enter applicable "individual" or "single" and "family" or "non-single" annual deductibles for the plan as a whole. Indicate whether they are aggregate or separate deductibles. Carriers shall identify what services are subject to the deductible by making a text notation next to those services in items 8 through 31 of the Colorado Health Benefit Plan Description Form. If the plan does not require deductibles, enter "No deductibles."

Question 5, Out-of-Pocket Annual Maximum*. Enter applicable out-of-pocket individual and family annual maximums. If the out-of-pocket maximum excludes deductibles and/or copayments, so indicate. If the plan has combined in-network and out-of-network annual out-of-pocket maximums, so indicate. Carriers may identify what deductibles and copayments are included in calculating the out-of-pocket maximums by making a text notation next to any applicable deductibles or copayments in items 8 through 31 of the Colorado Health Benefit Plan Description Form. If the plan has no out-of-pocket maximum, enter "No out-of-pocket maximum."

Question 6, Lifetime/benefit Maximum*. Enter lifetime maximum (e.g., "$2 million") and other benefit maximums that apply to the whole policy (e.g., "$50,000 per year" or "$20,000 per episode of care"). If lifetime/benefit maximums apply to both in-network and out-of-network expenses, so indicate. If the plan has no lifetime maximum, enter "No lifetime maximum."

Question 7A, Covered Providers. Indicate covered providers. Select one of the following choices only: (1) "[Insert name of provider network]. See provider directory for complete list of current providers"; (2) "[Insert total number] physicians and [Insert total number] hospitals in Colorado as of [insert date]. See provider directory for complete list of current providers"; or (3) "All providers licensed or certified to provide covered benefits."

Question 7B, Accessibility of Providers. One purpose of this question is to get at the so-called "pod" issue. In some plans, once an enrollee selects a PCP, that PCP only refers to a selected subset of otherwise covered network providers, sometimes called a pod. The subset is usually a physician-hospital network that has made special arrangements with the carrier concerning provider payment. An enrollee who wants to be referred to a specialist who is covered by his plan as a network provider but who is not part of his PCP's pod would have to select a new PCP who practices in the same pod as the specialist in order to get a referral. Select one of the following choices only: Network plans using this kind of pod system should answer "No"; all other network plans should answer "Yes". If the answer depends on the service area or some other factor, so indicate (e.g., "Yes, except in Denver and Adams County.")

A note should be added if the Plan includes network providers located over state or county lines.

Plans that do not use networks should enter: "Not applicable. This is not a network plan."

Questions 8-30: General Directions.

Show benefit levels, including copayments, coinsurance, and other applicable payment. If deductibles or copayments can vary by provider, disclose how this will apply. Indicate significant benefit limits. If per diem, annual, or per visit maximums apply, show them. If separate deductibles apply, so indicate. Examples: "80% for up to 6 visits per year," or "80% for generic drugs only," or "$10 per visit copayment," or "$50 per day up to $500 per year," or "50% after separate $100 per year physical therapy deductible," or "50% for 2 acute care detoxifications per year." If no coverage is provided for a category of benefit write in "Not covered." If full coverage is provided, write in "No copayment (100% covered)". Coinsurance options should reflect the carrier's reimbursement level.

HMOs that use one rather than two columns to describe their benefits should note in the appropriate boxes where the plan does cover out-of-network care (e.g., emergency care).

Question 8, Medical Office Visits. Indicate coverage for primary care provider and specialist services separately.

Question 9, Preventive Services. Carriers are reminded that Colorado law has benefit mandates regarding the coverage of children's preventive services (all individual and group health benefit plans). Indicate coverage for children's and adult preventive services separately. A complete, detailed list of services does not need to be provided.

Question 10, Maternity. Carriers are reminded that Colorado law has benefit mandates regarding maternity care coverage (employer group plans only). Indicate coverage for prenatal care and for delivery and inpatient well baby care separately.

Question 11, Prescription Drugs*. Indicate the amount of coverage for prescription drugs. Also indicate whether the level of coverage is based on generic versus brand name drugs, use of a prescription drug card, and/or other requirements. Note if separate copayments and deductibles apply. Examples: "Separate $100 deductible. $8 copayment per prescription"; or "80% generic; 50% brand name drugs"; or "90% with prescription drug card. Maximum benefit of $200/month"; or "$5 per prescription for drugs on our approved list only." If a formulary is used, add this statement: "For drugs on our approved list, contact [position title], at [telephone number]."

Questions 12 and 13, Inpatient Hospital and Outpatient/Ambulatory Surgery. See General Directions for Questions 8-30, above.

Question 14, Laboratory & X-ray. If coverage, copayments, or deductibles for diagnostic benefits vary depending on whether they are associated with a medical office visit, so indicate.

Questions 15, 16 and 17, Emergency Care, Ambulance, and Urgent Care. If copayments or deductibles differ by service among emergency care, ambulance, or urgent care, so indicate.

Question 18, Biologically Based Mental Illness Care. For group plans issued or renewed on or after January 1, 1998, carriers must enter: "Coverage is no less extensive than the coverage provided for any other physical illness."

Question 19, Other Mental Health Care*. Carriers are reminded that Colorado law has benefit mandates for group plans regarding the coverage of other, non-biologically based mental health conditions. If coverage varies depending on whether inpatient or outpatient, so indicate.

Question 20, Alcohol & Substance Abuse*. See General Directions for Questions 8-30, above. If coverage varies depending on whether the care is inpatient or outpatient, so indicate. Also

indicate if coverage varies depending on whether care is for alcohol versus other substance abuse.

Question 21, Physical, Occupational and Speech Therapy. If benefit levels vary, so indicate. Example: "Physical therapy: 50% maximum for up to six visits per event; Occupational: 80%; Speech: not covered." If coverage varies depending on whether inpatient or outpatient, so indicate.

Question 22, Durable Medical Equipment*. Carriers must indicate benefit level. Carriers may also add the following statement: "See policy for types and circumstances of coverage." If coverage varies depending on whether inpatient or outpatient, so indicate.

Questions 23, 24, 25, 26 and 27. See General Directions for Questions 8-30, above. If coverage varies depending on whether inpatient or outpatient, so indicate.

Questions 28-30, Dental Care, Vision Care and Chiropractic Care*. Briefly describe coverage, if any, and note if coverage may be obtained either under a separate dental/vision/chiropractic care plan or as an optional benefit. If no coverage is provided, write in "No coverage".

Question 31, Significant Additional Covered Services. You may list up to five additional covered benefits not already asked about in questions 10-30. Examples: acupuncture; other alternative medical treatments; transportation. Information specifying the plan's cancer screening coverages, as required by Section 10-16-108.5(11)(c), C.R.S., must be included in box 31 if it is not included at the end of the form or attached as allowed by Section 4.I.4. of this regulation. Information regarding cancer screening coverages counts as only one (1) of the five (5) additional services that can be listed in this box.

PART C: LIMITATIONS AND EXCLUSIONS

Question 32, Pre-existing Condition Exclusion Period. Select one of the following choices only: (1) "____ months [insert the length of the limitation period] for all pre-existing conditions"; (and for business groups of one the limitation period may not exceed 12 months.) (2) "____ months [insert the length of the limitation period] for selected pre-existing conditions only; no pre-existing condition limitation for all other conditions. See policy for details."; (3) "Not applicable; plan does not impose limitation periods for pre-existing conditions." (4) "This individual short-term health benefit plan does not cover pre-existing conditions." Note: For group plans (except business groups of one) the limitation period may not exceed six (6) months; for business groups of one the limitation period may not exceed 12 months. Individual carriers that use pre-existing exclusion periods shall also add the following to their answer: "unless the covered person is a HIPAA-eligible individual as defined under federal and state law, in which case there are no pre-existing condition exclusions." This additional language is not applicable to individual short-term health benefit plans. Carriers are reminded that Colorado law governs allowable pre-existing periods for all health benefit plans.

Question 33, Exclusionary Riders. All group carriers must enter "No". Depending on the policy, individual carriers should enter "Yes" or "No."

Question 34, Definition of a Pre-existing Condition. Enter the definition of a pre-existing condition under this policy. Select one of the following choices only: (1) "Not applicable. Plan does not exclude coverage for pre-existing conditions."; (2) for group plans: "A pre-existing condition is a condition for which medical advice, diagnosis, care, or treatment was recommended or received within the last ___ [insert a number not to exceed 12 for business groups of one and not to exceed 6 for all other group plans] months immediately preceding the date of enrollment or, if earlier, the first day of the waiting period; except that pre-existing condition exclusions may not be imposed on a newly adopted child, a child placed for adoption, a newborn, other special enrollees, or for pregnancy"; (3) for individual plans: "A pre-existing condition is an injury, sickness or pregnancy for which a person incurred charges, received medical

treatment, consulted a health care professional, or took prescription drugs within ___ [insert a number not to exceed 12] months immediately preceding the effective date of coverage."; or (4) for individual short-term health benefit plans: "Pre-existing conditions are not covered."

Question 35, Policy Exclusions. All carriers must enter the following language: "Exclusions vary by policy. A list of exclusions is available immediately upon request from your carrier, agent, or plan sponsor (e.g., employer). Review the list to see if a service or treatment you may need is excluded from the policy." On demand, carriers must give applicants and insureds a complete list of exclusions. Carriers are encouraged, but not required, to list the exclusions in alphabetical order (e.g., custodial care; enteral feedings; growth hormone therapy; health services which are not medically necessary; travel or transportation expenses except for ambulance).

PART D: USING THE PLAN

Questions 36-38: General Directions. If the plan has separate in-network and out-of-network benefits, use two columns and label them "In-network" and "Out-of-network." If the plan does not make such a distinction (e.g., a traditional indemnity plan), replace two columns with a single column labeled "Using the Plan."

Questions 36, 37, and 38, Specialty Care, Surgical Procedures, and Provider Charges. In each column, select one of the following choices only: (1) "Yes" or (2) "No." If the answer is "Yes", a carrier may expand on the answer to note exceptions to this requirement (e.g., "Yes, except for obstetrical or gynecological care.")

Question 39, Customer Service Number. Enter your main customer service number for members/insureds.

Question 40, Filing Complaints. Enter name, address and phone number for complaints and grievances.

Question 41, Dissatisfaction With Resolution of Consumer Complaint. Except as noted, all plans enter: "Write to: Colorado Division of Insurance, ICARE Section, 1560 Broadway, Suite 850, Denver, CO 80202."

Question 42, Form Number, Group Size, and Short-Term. Enter the policy form number by writing "Policy form # ___ [fill in]". Indicate whether this is an individual, small, or large group policy. Select one of the following choices only: (1) "Individual", (2) "Small group only", (3) "Large group only", or (4) "Group--all sizes." Indicate if policy is short-term by writing "short term policy." Examples: "Policy form # CO-1247, large group." or "Policy form # 12-30-7, individual, short-term." Note: If a carrier offers the identical policy in several markets (e.g., large group market, small group market, etc.) then multiple responses may be included here (e.g., "Policy form #CO-1247 large group, and #CO-807 small group."

Question 43, Binding Arbitration. Indicate, with a "Yes" or "No", if the plan has binding arbitration.

OPTIONAL ATTACHMENT: SELECTED BENEFIT DESCRIPTIONS

Carriers are not required to use this form. At the carrier's option, with respect to questions 4-6,11, 19-20, 22, and 28-30 only, a carrier may describe its benefits with respect to these items on the optional attachment instead of on the main form. A carrier that chooses to do this must write in "See benefit schedule attached" for the designated questions and shall use the form labeled “Selected Benefit Descriptions,” which is found at the end of the description form and labeled Optional Attachment. The same rules apply for filling out the boxes on this optional form as on the main description form. Carriers using the optional attachment must attach it to all health plan description forms.

Endnote:

* For questions 4-6, 11, 19-20, 22 and 28-30, carriers may write in “See benefit schedule attached” and show actual benefit levels on a separate schedule attached to the form. Carriers shall use the form labeled “Specific Benefits Selected” which is shown as the Optional Attachment at the end of the form in Appendix A.